STATE OF DELAWARE
CHILD DEATH AND
STILLBIRTH REVIEW COMMISSION

Annual Report

January 1, 2003 - December 31, 2003

September 2005

Child Death and Stillbirth Review Commission
900 King Street
Wilmington, DE 19801-3341

Executive Summary

"CHILDREN ARE NOT SUPPOSED TO DIE."
Coleen Kivlahan, MD, MSPH
2004 National Symposium on Child Fatalities, August 2004

Between 1996 and 2000, the child death rate for children through age 14 was 24.2 per 100,000 children in the United States and 22.1 per 100,000 children in the State of Delaware. In these same years, 7.1 of every 1,000 infants died nationally; Delaware exceeded National Infant Mortality Rates with a rate of 8.4 deaths per 1,000 births (Kids Count in Delaware, Families Count in Delaware, Fact Book, 2003).

Every child death is a tragedy, especially when the death could have been averted. Child death review processes have been implemented throughout the United States to help understand how and why children die, and to implement changes to prevent future deaths of our most vulnerable citizens.

Delaware's child death review legislation enacted by the General Assembly strives to prevent child mortality in this State. The Child Death and Stillbirth Review Commission, and its Regional Panels, conduct retrospective reviews of all child deaths occurring in the State of Delaware to make meaningful and timely system-wide recommendations to support this goal. The process brings professionals and experts from a variety of disciplines together to form multi-faceted recommendations and encourage interagency collaboration to end child deaths in Delaware.

Deaths which are determined to have been "preventable" lead to multidisciplinary discussion and development of recommendations to prevent future child deaths. Cases which involve abuse and/or neglect of a child are expedited, in order to make and implement recommendations as quickly as possible. The Commission reports its recommendations to the Governor and General Assembly.

In the calendar year 2003, the Commission and Regional Panels completed reviews of 174 child deaths in Delaware. Nearly three percent (3%) of the child deaths reviewed were determined to be preventable deaths, meaning one or more interventions by medical, community, legal and/or psychological systems might reasonably have averted these deaths. Recommendations for system improvements are made even in cases where the death of a child was not deemed preventable.

The Commission is committed to continued growth to make improving the care and safety of Delaware's children a top priority.

Special Note

The members of the Child Death and Stillbirth Review Commission extend their special thanks to citizens who have served on the Commission and its Regional Panels.
The Commission recognizes the significant time, energy and sacrifice made by the volunteer members of the Regional Panels, and their commitment to the future of the children of Delaware.

Without the hard work, expertise and dedication of panel members, the Commission could not carry out its duty to prevent the deaths of children in the State of Delaware.

The Commission would also like to thank Attorney General M. Jane Brady and Secretary Cari DeSantis for providing support staff to the Commission, and the staff of the Office of the Child Advocate for their work on previous annual reports. Your dedication to Delaware's children is appreciated.

Table of Contents

I. Mission/Purpose

II. General Background
- A. Introduction
- B. Structure and Membership
- C. Duties and Responsibilities
- D. Review Process

III. Child Death Reviews in Delaware - 2003
- A. Overview
- B. Commission and Panel Activity - 2003
  1. New Castle County Panel
  2. Kent/Sussex County Panel
  3. Commission
  4. Accomplishments and Challenges - 2003
- C. Cause/Manner of Death for Delaware Children Ages 0 - 17
- D. Deaths Reviewed by Age, Gender and Race
- E. Deaths Reviewed by County

IV. Summary

V. Recommendations
- A. Preventable Deaths
- B. Recommendations

Appendices
- (A) Commissioners and Panel Members
- (B) Child Death and Stillbirth Review Commission Legislation - 2003

I. Mission/Purpose

The 142nd General Assembly of the State of Delaware declared:

> "...the health and safety of the children of the State will be safeguarded if deaths of children under the age of 18, and stillbirths occurring after at least 27 weeks of gestation are reviewed, in order to provide recommendations to alleviate those practices or conditions which impact the mortality of children." (Title 31, Part I, Ch.3, Subch. II, § 320).

The Child Death and Stillbirth Review Commission (formerly the Child Death Review Commission), and its Regional Panels, conduct retrospective reviews of every child death in Delaware, in order to provide meaningful, prompt, system-wide recommendations to alleviate the mortality of children and improve services to the children of Delaware.

II. General Background

A. Introduction

Delaware's initiative to prevent mortality of its children began in 1988 with the Office of the Attorney General's Abuse Intervention Committee. Delaware Code first established its Child Death Review Commission in July 1995, after a pilot project demonstrated the importance of a child death review process to prevent future deaths of children in the State. By 2003, legislation evolved to amend the name of the Commission to the Child Death and Stillbirth Review Commission and include reviews of stillbirths.

The death of a child is a community problem. Often, circumstances involved in the deaths of children are unknown. When risk factors are determined, they are multidimensional. Prevention of child deaths is complex and requires a multi-disciplinary, public-private approach.

The Delaware Child Death and Stillbirth Review Commission is a statewide consortium of experts and leaders from multiple systems, disciplines, and private and public agencies joined together to help identify the complex factors related to child deaths in Delaware. As these factors are identified, recommendations are made for systemic improvements in the future, with the goal of ending preventable deaths of children in this State.

B. Structure and Membership

The Commission is mandated to meet at least semi-annually. Legislation in 2003 allowed for two regional Child Death Review Panels whose members are appointed by the Commission.

The two Regional Panels meet monthly. These Panels review in detail all child deaths occurring in the State. One Panel represents New Castle County; the second Panel represents both Kent and Sussex Counties.

The Child Death and Stillbirth Review Commission and Regional Panel members are designated in Title 31, Part I, Ch. 3, Subch. II, § 321. Appendix A includes a table of Commissioners and Panel Members serving in 2003.

C. Duties and Responsibilities

Title 31, Part I, Ch.3, Subch. II, §323 gives the Child Death and Stillbirth Review Commission the power to investigate and review all deaths of children and stillbirths which occur in Delaware. In the event that a child death occurs as a result of abuse and/or neglect, the Commission must conduct an expedited review within 3 months of notice of such a death or near death. Notice must come from the Attorney General, the Department of Services for Children, Youth and their Families, or any other agency responsible for investigating child deaths. These reviews may be extended to 6 months for good cause.

At least annually, the Commission is responsible to make recommendations to the Governor and General Assembly regarding practices impacting the mortality of children.

Review Process

The Child Death and Stillbirth Review Commission utilizes retrospective reviews of child deaths to make recommendations with the goal of preventing future deaths of children in Delaware. In 2003, the Commission approved formalized procedures for case reviews. These procedures were based on those created in the past by the Abuse Intervention Committee of the Attorney General's Office.

Reviews of child deaths due to abuse and/or neglect are expedited, and completed within 3 to 6 months. Recommendations from expedited reviews are submitted to the Governor and the General Assembly in a letter within 20 days of completion of the review. All other recommendations are submitted to the Governor and General Assembly in the annual report. All recommendations of the Commission are available to the public.

III. Child Death Reviews in Delaware - 2003

A. Overview

The following table depicts the number of child death cases reviewed by both Regional Panels and the Commission in calendar year 2003. Three percent (3%) of all child deaths reviewed were determined to be preventable by the panels and commission.

For the purpose of Delaware's Child Death Review Process, preventable death is defined as:

> "One or more interventions (medical, community, legal, psychological) might reasonably have averted the child's death."

2003 Child Deaths - Number of Completed Reviews

Number of Deaths Reviewed	174
Number of Preventable Deaths	5
Percentage of Deaths deemed Preventable	3%

B. Commission and Panel Activity - 2003

1. New Castle County Panel

The following table depicts the activities of the New Castle County Panel and the physician review of deaths of infants less than 28 days old in New Castle County. Overall, 115 child deaths occurring in New Castle County were reviewed by the New Castle County Panel and its physician members in 2003. This constitutes **66% of all statewide child death reviews** completed during the year.

New Castle County Panel - 2003 Child Death Reviews Completed

Number of Times Panel Met	9
Number of Child Deaths Reviewed by Panel	43
Percent of all Deaths Reviewed Statewide	24.7%
Number of Deaths Reviewed by Panel (child<1 yr old)	13
Number of Deaths Reviewed (child 1 yr - 17 yrs old)	30
Number of Male Deaths Reviewed	32
Number of Female Deaths Reviewed	11
Number of Deaths - Black	20
Number of Deaths - Caucasian	16
Number of Deaths - Hispanic	4
Number of Deaths - Other Race	3
Percent of Deaths Reviewed - Preventable	1
Number of Physician Reviews of Infants	**72**

Of the child deaths reviewed by the panel, 30% were deaths of infants between 28 days old and one year old. **62.6%** of all deaths reviewed by the panel and physician were infants under 1 year. The majority (46.5%) of deaths of children over 28 days old reviewed were black children. Males accounted for 74.4% of child deaths (over 28 days old) reviewed.

2. Kent/Sussex County Panel

The following table depicts the activities of the Kent/Sussex Regional Panel and the physician review of deaths of infants less than 28 days old in both Kent and Sussex Counties. Overall, 59 child deaths occurring in both counties were reviewed by the Kent/Sussex Regional Panel and its physician members in 2003. This represents **34% of all child death reviews** conducted statewide during the calendar year.

Kent/Sussex County Panel - 2003 Child Death Reviews

Number of Times Panel Met	6
Number of Child Deaths Reviewed	24
Percent of all Deaths Reviewed Statewide	13.8%
Number of Deaths Reviewed by Panel (child<1 yr old)	11
Number of Deaths Reviewed (child 1 yr - 17 yrs old)	13
Number of Male Deaths Reviewed	15
Number of Female Deaths Reviewed	9
Number of Deaths - Black	11
Number of Deaths - Caucasian	12
Number of Deaths - Hispanic	1

Number of Deaths - Other Race	0
Percent of Deaths Reviewed - Preventable	4
Number of Physician Reviews of Infants	35

Of the child deaths reviewed by the panel, 45.8% were deaths of infants between 28 days old and one year old. 59.3% of all deaths reviewed by the panel and physician were infants under 1 year. The majority (50%) of deaths of children over 28 days old reviewed were Caucasian children. Males accounted for 62.5% of child deaths (over 28 days old) reviewed.

3. Commission

Child Death and Stillbirth Review Commission - 2003 Activity

Number of Commission Meetings	4
Number of Panel Reports Reviewed/Approved	7

4. Accomplishments and Challenges - 2003

Accomplishments:

- 100% of all deaths referred via copy of death certificate from the Division of Public Health were reviewed, unless deferred.
- A "tracking tool" was developed to monitor recurring factors in death over time, such as sleeping position of infants.
- A process subcommittee was developed and a handbook of review processes was created.
- The Commission supported HB 106, increasing penalties for youth not wearing seatbelts.

Challenges:

- Issues needed to be addressed related to the right of parents to release educational records of a child, even after the child's death (FERPA).

C. Cause/Manner of Death for Delaware Children Ages 0 - 17

The following data describes causes of death, and manner of death in child death cases reviewed by Regional Panels in 2003 in relation to the age, gender, and race of the child.

Causes of Child Deaths Reviewed

Cause of Death	# of Child Deaths	% of all Child Deaths Reviewed
Non-natural Causes of Death		
Drowning	2	1.1%
Fire	0	0%
Homicide	3	1.7%
Machinery	0	0%
Other	2	1.1%
Suicide	4	2.3%
Vehicular Crashes	**15**	**8.6%**
Subtotal Non-natural	**26**	**14.8%**
Natural Causes of Death		
Asthma	1	0.6%
Congenital Defects	9	5.2%
Dehydration	2	1.1%

Heart Failure/ Heart Disease	12	6.9%
Pneumonia	2	1.1%
Prematurity	**85**	**48.9%**
Renal Failure	3	1.8%
Respiratory Failure	5	2.9%
SIDS/SUDI	6	3.5%
Sepsis	4	2.3%
Other Natural/Unknown	19	10.9%
Subtotal Natural	**148**	**85.2%**
Total	**174**	**100%**

It is worthy to note that 48.9% of all deaths reviewed were related to prematurity. This is the highest natural cause of death in children. Vehicular crashes accounted for the majority of non-natural deaths of children.

D. Death Reviews Completed by Age, Gender and Race

Manner of Death Reviewed by Age

Manner of Death	<1 yr	1-4 yrs	5-9 yrs	10-14 yrs	15-17yrs	Total
Natural	124	6	5	3	2	140
Accidental	1	2	1	4	11	19
Suicide	0	0	0	1	3	4
Homicide	0	0	0	2	1	3
Pending	0	0	0	0	0	0
Undetermined	6	2	0	0	0	8
Total	131	10	6	10	17	174

Of the 174 child deaths reviewed in 2003, the majority were due to natural causes. However, 88.6% of natural child deaths were infant deaths (under 1 year of age.) The majority of accidental child deaths (57.9%) involved a child 15 - 17 years old. This age group also accounted for 75% of all suicides.

Manner of Death Reviewed by Gender

Manner of Death	Male	Female	Unknown	Total
Natural	89	50	1	140
Accidental	14	5	0	19
Suicide	4	0	0	4
Homicide	3	0	0	3
Pending	0	0	0	0
Undetermined	6	2	0	8
Total	116	57	1	174

Of all child deaths reviewed, 63.6% involved a male child. The majority of accidental deaths (73.7%) involved males, and 100% of child suicides and homicides involved males.

Manner of Death Reviewed by Race

Manner of Death	Black	Caucasian	Hispanic	Other/Unknown	Total
Natural	67	61	6	6	140
Accidental	6	12	0	1	19
Suicide	1	3	0	0	4
Homicide	1	2	0	0	3

Pending	0	0	0	0	0
Undetermined	6	2	0	0	8
Total	81	80	6	7	174

Of the 2003 child deaths reviewed, deaths by accident and suicide involved primarily Caucasian children (63.2% and 75%), and Caucasians represented 2/3 of all homicides reviewed. The majority of natural deaths **(47.8%) occurred in black children.**

E. Deaths Reviewed by County

The following data describes child deaths reviewed by county of death in relation to the age and manner of death of the child.

Deaths Reviewed by Age and County

County	# Deaths <1 yr	# Deaths 1 -17 yrs	Total Deaths	% of Statewide Deaths
New Castle	85	30	115	66.09%
Kent	30	4	34	19.54%
Sussex	16	9	25	14.37%

Manner of Death Reviewed by County

Manner of Death	# NCC	%NCC*	#Kent	%Kent*	# Sussex	%Sussex*
Natural	96	83.5%	28	82.4%	16	64.0%
Accidental	12	10.5%	3	8.8%	4	16.0%
Suicide	3	2.6%	1	2.9%	0	0.0%
Homicide	1	0.9%	0	0.0%	2	8.0%
Pending	0	0.0%	0	0.0%	0	0.0%
Undetermined	3	2.6%	2	5.9%	3	12.0%
Total	115	100.0%	34	100.0%	25	100.0%

*Percentage of all child deaths reviewed in that county due to a particular manner of death

IV. Summary

Of 174 child deaths reviewed in 2003, 124 (or 95%) were deaths by natural causes of infants less than one-year old. Adolescents (15-17 y/o) comprised the majority (57.8%) of accidental deaths reviewed. 75% of child suicides reviewed were by adolescents; one child suicide was a child between 10 and 14 years old. Seventy-five percent of suicides were by Caucasian children.

The majority of child deaths reviewed involved the death of a male child (66.7%). This rate is higher than the percentage of male children in Delaware in 2000 (51% per Families Count in Delaware Fact Book, 2003). Black children accounted for 46.6% of all child deaths reviewed.

V. Recommendations

A. Preventable Deaths

For the purpose of Delaware's Child Death Review Process, preventable death is defined as:

> "One or more interventions (medical, community, legal, psychological) might reasonably have averted the child's death."

This definition has been adopted by the Commission in an effort to maintain a focus on systems issues vs. individual responsibility. Recommendations are made by panels and approved by the Commission based on systems challenges/needs identified, particularly in cases of preventable death.

Statewide Child Deaths Reviewed and Found Preventable

Total Number Cases Reviewed	# Preventable	# Not Preventable	# Unknown/Split Vote	% Preventable
174	5	142	27	2.9%

New Castle County Preventable Deaths Reviewed

Number of Cases Reviewed	115
Number Preventable Child Death	1
% Cases Preventable	0.87%

Kent County Preventable Deaths Reviewed

Number of Cases Reviewed	34
Number Preventable Child Death	2
% Cases Preventable	5.9%

Sussex County Preventable Deaths Reviewed

Number of Cases Reviewed	25
Number Preventable Child Death	2
% Cases Preventable	8.0%

In 2003, nearly 3% of all child deaths reviewed were determined to have been preventable. While the majority (66%) of child deaths reviewed were residents of New Castle County, the number of preventable deaths in each of Kent and Sussex Counties was twice that in New Castle County. Although not defined as preventable from a system-perspective, premature birth was a factor in nearly half of all child deaths reviewed.

The Child Death and Stillbirth Review Commission hopes that the recommendations put forth in this report may alleviate preventable deaths of children in all of Delaware's counties in the future.

B. Recommendations

The Commission makes the following recommendations based on reviews completed in 2003:

- The Division of Public Health should review public pool safety requirements and consider opportunities to reinforce appropriate signage requirements.
- Implement seasonal public notification of the importance of adult supervision of children in pools, and water safety.
- Provide periodic public notice to parents of their responsibilities to supervise their children and the consequences of leaving children unattended.
- Provide support for nursing education, including support for financial assistance for nursing education programs and increased public awareness of professional opportunities in the nursing field.
- Expand public programs, such as weekend daycare and respite programs, for children with special medical needs.

- Develop and implement an internal review process within Medicaid to verify actual service provision versus authorized services.
- Provide continued funding for programs designed to keep kids safe, such as Safe Kids Coalition.
- Encourage groups involved in outreach to address car seat safety.
- Support Sex Education in schools, and programs that teach and encourage parents how to communicate with their children about sex.
- The Department of Services for Children, Youth and Their Families should develop and implement a transfer of information form, and send a letter to contracted providers regarding the need for new prescriptions if a dosage is changed. Training regarding the process for when medications have changed should also be provided to department and contractor staff.
- Consider stiffer penalties for a second offense of improper restraint of a child.

Appendix A - Commissioners, Proxies and Regional Panel Members - 2003

Child Death and Stillbirth Review Commissioners

Commissioner	Legislative Role
Dr. Steven Berlin	Kent/Sussex Rep OB/GYN
The Honorable M. Jane Brady	State Attorney General
Dr. Richard T. Callery	Office of the Medical Examiner
Col. L. Aaron Chaffinch	Delaware State Police
Dr. Garrett H.C. Colmorgen	Perinatologist
Dr. James J. Cosgrove	OB/GYN
Ms. Tania M. Culley, Esq.	State Child Advocate
Col. John Cunningham	New Castle County Police Department
Lt. Mark Daniels	Delaware State Police
Mr. Allan J. Daul	Child Advocate
The Honorable Secretary Cari DeSantis	Department of Services for Children, Youth and Their Families
Ms. Helene Diskau	Delaware Nurses Association
Capt Harry Downes	Delaware State Police - Proxy
Dr. John A.J. Forest	Pediatrician
Ms. Trish Hearn	Department of Services for Children, Youth and Their Families - Proxy
Ms. Marjorie Lynn Hershberger	Chair, New Castle County Panel
Dr. Kathy A. Janvier	Delaware Nurses Association
Cpt. James Jubb	Police Chiefs Council of Delaware - Proxy
Ms. Mariann Kenville-Moore	State Attorney General - Proxy
Dr. William Lybarger	Department of Education
Col. David McAllister	New Castle County Police Department
Ms. Mary Kate McLaughlin	Department of Health and Social Services
The Honorable Secretary Vincent P. Meconi	Department of Health and Social Services
Ms. Janice Mink	Child Advocate (Non-Profit)
Dr. Lani Nelson-Zlupko	National Association of Social Workers
Dr. David Paul	Neonatologist
Ms. Anne Pedrick	State Child Advocate - Proxy
Ms. Marie E. Renzi	Child Advocate (Non-Profit)
Dr. Philip Shlossman	Chair, Kent/Sussex Panel
Dr. Kevin Sheahan	Pediatrician
Chief Michael J. Szczerba	Police Chiefs Council of Delaware
Sgt. Renee Taschner	New Castle County Police Department
The Honorable Secretary Valerie Woodruff	Department of Education

Key Support Staff

Ms. Karen Golden
Mr. Stuart Mast
James Maxwell, Esq.

New Castle County Regional Panel Members - 2003

Member/Proxy	Legislative Role
Ms. Marjorie Lynn Hershberger	Delaware Nurses Association
Ms. Anne Pedrick	Office of the Child Advocate
Dr. Adrienne Sekula-Perlman	Office of the Medical Examiner
Sgt. William Browne	Wilmington Police Department
Ms. Cathie Frost	Department of Health and Social Services
Ms. Linda Hawthorne	Citizen Interested in Child Death
Ms. Christine Stapleford	Department of Health and Social Services
Sgt. Gerard Donovan	New Castle County Police Department
Ms. Mary Crowley	Child Advocate
Ms. Michele Ostafy	Child Advocate
Mr. John Humphrey	Child Advocate
Lt. John Evans	Delaware State Police
Sgt. Michael Kelly	New Castle County Police
Ms. Pat Pheris	Division of Substance Abuse and Mental Health
Capt. Harry Downes	Delaware State Police
Dr. Jennie Vershvovsky	Office of the Medical Examiner
Dr. Ross Megargel	Office of Emergency Medical Services
Sgt. Renee Taschner	New Castle County Police
Sgt. Phillip Hill	New Castle County Police

Kent/Sussex County Regional Panel Members - 2003

Member/Proxy	Legislative Role
Dr. Philip Shlossman	Perinatology
Mr. James Adkins	Department. of Justice
Ms. Carla Benson-Green	Division of Family Services
Dr. Steven Berlin	OB/GYN
Lt. Lester Boney	Dover Police Department
Det. Kenneth Brown	Milford Police Department
Lt. Benton Counselman	Dover Police Department
Rev. Mary Craig-Young	Division of Public Health
Ms. Barbara DeBastiani	Division of Public Health
Ms. Helen Diskau	Delaware Nurses Association
Lt. John Evans	Delaware Sate Police
Ms. Angela Fowler, Esquire	Office of the Child Advocate
Dr. Fran Franklin	Child Advocate
Lt. Robert Hawkins	Delaware State Police
Ms. Cherelyn Homlish	Child Advocate
Ms. Jackie Howard	Citizen Interested in Child Death
Dr. Patrick Jarvie	DuPont Pediatrics
Ms. Rosemary Joseph-Kappel	Department of Health and Social Services
Lt. James Kurtz	Dover Police Dept
Mr. Stuart Mast	Department of Services for Children, Youth and their Families
Ms. Melissa McGinty	Mental Health Center
Mr. Neil McLaughlin	Department of Health and Social Services
Dr. Ross Megargel	Office of Emergency Medical Services
Dr. Walter Omans	Pediatric Care
Ms. Pat Pheris	Division of Substance Abuse and Mental Health
Dr. Judith Tobin	Office of the Medical Examiner
Ms. Maxine Travis	National Association of Social Workers
Ms. Linda C. Wolfe	Department of Education

Appendix B

Child Death and Stillbirth Review Commission Legislation – 2003

§ 320. | § 321. | § 322. | § 323. | § 324.

TITLE 31

Welfare

PART I

In General

CHAPTER 3. CHILD WELFARE

Subchapter II. Child Death and Stillbirth Review Commission

§ 320. Declaration of legislative intent.

~~The General Assembly hereby declares that the health and safety of the children of the State~~ will be safeguarded if deaths of children under the age of 18 and stillbirths occurring after at least 27 weeks of gestation are reviewed in order to provide recommendations to alleviate those practices or conditions which impact the mortality of children. This subchapter establishes the Child Death and Stillbirth Commission. For the purposes of this subchapter, "Commission" means the Child Death and Stillbirth Commission. Stillbirths occurring after at least 27 weeks of gestation shall not include stillbirths which occur as a result of an elective medical procedure. (70 Del. Laws, c. 256, § 1; 73 Del. Laws, c. 331, §§ 2, 3.)

§ 321. Organization and composition.

(a) The following shall be members of the Commission: The State Attorney General, the Secretary of the State Department of Health and Social Services, the Secretary of the State Department of Services to Children, Youth and Their Families, the person appointed as the child advocate pursuant to § 9003A of Title 29, the State Secretary of Education, the State Medical Examiner, and the Superintendent of the Delaware State Police, or the designee of any of the preceding persons. Additionally, the following shall be appointed by the Governor as members of the Commission: (i) A representative of the Medical Society of Delaware specializing in each of pediatrics, neonatology, obstetrics and perimatology; (ii) a representative of the Delaware Nurses Association; (iii) a representative of the National Association of Social Workers; (iv) a representative of the Police Chiefs' Council of Delaware who is an active law enforcement officer; (v) a representative of the New Castle County Police Department; and (vi) 2 child advocates from state-wide non-profit organizations. A Chairperson of each regional child death and stillbirths review panel established pursuant to subsection (d) hereof shall also serve as members of the Commission. The term of members appointed by the Governor shall be 3 years and shall terminate upon the Governor's appointment of a new member to the Commission. The members of the Commission and of the regional panels shall serve without compensation. Subject to the availability of the appropriate and necessary funding, the Commission shall have the authority to appoint staff members to whom certain duties and authority may be delegated as deemed appropriate by the Commission.

(b) The Commission shall, by affirmative vote of a majority of all members of the Commission, appoint a chairperson from its membership for a term of 1 year. The Commission shall meet at least semi-annually.

(c) Meetings of the Commission and regional panels shall be closed to the public.

(d) The Commission shall by resolution passed by a majority of its members establish at least 1 but no more than 3 regional child death and stillbirth review panels. Members of the Commission shall appoint representatives to each regional panel such that the regional panel reflects the disciplines of the Commission. The Commission shall also appoint to each regional panel (i) a representative from each of the 3 police departments which investigate the majority of child deaths in the region covered by the panel, and (ii) a citizen of the region interested in child death and stillbirth issues.

(e) Each regional panel shall have the powers, duties and authority of the Commission as delegated by the Commission. Each regional panel shall, by affirmative vote of a majority of all members of that regional panel, appoint co-chairpersons from its membership for a term of 1 year. (70 Del. Laws, c. 256, § 1; 72 Del. Laws, c. 327, § 1; 73 Del. Laws, c. 65, § 43; 73 Del. Laws, c. 331, §§ 4, 5.)

§ 322. Voting.

Except as expressly provided herein, an affirmative vote of 60% of all members of the Commission or any regional panel shall be required to adopt any findings or recommendations of the Commission or such regional panel. (70 Del. Laws, c. 256, § 1.)

§ 323. Powers and duties.

(a) The Commission shall have the power to investigate and review the facts and circumstances of all deaths of children under the age of 18 and stillbirths which occur in Delaware. The review of deaths involving criminal investigations will be delayed until the later of the conclusion of such investigation, or the adjudication of related criminal charges, if any. The Commission shall make recommendations to the Governor and the General Assembly, at least annually, regarding those practices or conditions which impact the mortality of children. System-wide recommendations arising from an investigation and review conducted pursuant to subsection (e) of this section shall be made to the Governor and General Assembly, as well as any members of the public requesting the recommendations, within 20 days of the completion of such investigation and review. All recommendations made pursuant to this subsection shall comply with applicable state and federal confidentiality provisions, including but not limited to those enumerated in § 324 of this title and § 9017(d) of Title 29. Notwithstanding any provision of this subchapter to the contrary, such recommendation shall not specifically identify any individual or any nongovernmental agency, organization or entity.

(b) The Commission shall conduct reviews according to procedures promulgated by the Abuse Intervention Committee of the State Attorney General's Office, which procedures shall be adopted in writing prior to the 1st review. The Commission may amend such procedures upon a three-quarters affirmative vote of all members of the Commission.

(c) In connection with any review, the Commission shall have the power and authority to:

(1) Administer oaths; and

(2) Compel the attendance of witnesses whose testimony is related to the death under review and the production of records related to the death under review by filing a praecipe for a

subpoena, through the Attorney General or a Deputy Attorney General, with the Prothonotary of any county of this State, such a subpoena to be effective throughout the State and service of such a subpoena to be made by any sheriff of the State; failure to obey said subpoena will be punishable according to the rules of the Superior court.

(d) Notwithstanding any provision of this subchapter to the contrary, no investigation or review shall be made of a stillborn if either parent objects.

(e) Notwithstanding the above, the Commission shall investigate and review the facts and circumstances of the death of an abused and/or neglected child within 3 months of a report to the Commission by the Attorney General, the Department of Services for Children, Youth and Their Families, or other state agency that the deceased child was the victim of abuse or neglect. The Attorney General, the Department of Services for Children, Youth and Their Families, and any other state or local agency with responsibility for investigating child deaths shall report to the Commission any death of a child who is determined to have been abused and/or neglected within 14 days of that determination.

(f) Notwithstanding any provision of this subchapter to the contrary, no person identified by the Attorney General's office as a potential witness in any criminal prosecution arising from the death of an abused or neglected child shall be questioned, deposed or interviewed by or for the Commission in connection with its investigation and review of such death until the completion of such prosecution. (70 Del. Laws, c. 256, § 1; 73 Del. Laws, c. 331, §§ 6, 7; 73 Del. Laws, c. 386, §§ 1, 2, 6.)

§ 324. Confidentiality of records and immunity from suit.

(a) The records of the Commission and of all regional panels, including original documents and documents produced in the review process with regard to the facts and circumstances of each death, shall be confidential and shall not be released to any person except as expressly provided in Chapter 3, Subchapter II of this Title. Such records shall be used by the Commission, and any regional panel only in the exercise of the proper function of the Commission or regional panel and shall not be public records and shall not be available for Court subpoena or subject to discovery. Subject to constitutional requirements, statements, records or information shall not be subject to any statute or rule that would require those statements to be disclosed in the course of a criminal trial or associated discovery. Aggregate statistical data compiled by the Commission or regional panels, however, may be released at the discretion of the Commission or regional panels.

(b) Members of the Commission and of the regional panels, and their agents or employees, shall not be subject to, and shall be immune from, claims, suits, liability, damages or any other recourse, civil or criminal, arising from any act, proceeding, decision or determination undertaken or performed or recommendation made, provided such persons acted in good faith and without malice in carrying out their responsibilities, authority, duties, powers and privileges of the offices conferred by this law upon them or by any other provisions of the Delaware law, federal law or regulations, or duly adopted rules and regulations of the Commission or its regional panels. Complainants shall bear the burden of proving malice or a lack of good faith to defeat the immunity provided herein.

(c) No person in attendance at a meeting of any such Commission or regional panel shall be required to testify as to what transpired thereat. No organization, institution or person furnishing information, data, reports or records to the Commission or any regional panel with respect to any subject examined or treated by such organizations, institution, or person, by reason of furnishing such information, shall be liable in damages to any person or subject to any other recourse, civil or criminal. (70 Del. Laws, c. 256, § 1; 73 Del. Laws, c. 386, §§ 3, 4.)